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ABSTRACT

The rhetorical aspects of psychotherapeutic theory may be examined by arranging the canons of rhetoric, the sources of persuasion, and some procedures of rhetorical behavior on one axis of a grid, then placing rhetorical/therapeutic situations on the other axis of the grid. In this way, the degree to which a rhetoric is used in psychotherapeutic interviews can be measured. This methodology was applied to the theory and therapeutic procedures of Harry Stack Sullivan, a noted psychotherapist. Although the rhetoric behind Sullivan's theories and procedures was found to be only partially complete, the study's methodology offers a way to begin remedying such incompleteness, enabling researchers to devise and refine strategies for use in predictable, therapeutic situations and to adapt familiar rhetorical criteria to therapeutic situations. (RL)

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A RHETORICAL FRAMEWORK FOR THE ANALYSIS OF PSYCHOTHERAPEUTIC THEORY

by

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The following study supports the position of two other papers on this panel to suggest that there is relevance to a scholarly examination of the rhetorical aspects of therapy. But instead of conducting rhetorical criticism to analyze therapeutic discourse as the other authors have done, the present discussion provides a methodology for extracting rhetorical notions from psychotherapeutic literature. Indeed, rhetoricians have only recently begun to take account of the connection. But for decades psychotherapists have been discussing an implicit rhetoric with potential applications for both fields.[1] The formal question "Is there a rhetoric in therapy?" is a new one for our field. Such an inquiry, however, is logically feasible because it appears that a rhetorical situation is present in the relationship between client and therapist. Consider the following:

1. Certainly there is an exigence. It is a need to modify the behavior of the client either by operation of the therapist or by self modification. The question for any psychotherapeutic system is, "does the therapist act in ritualistic or rule bound fashion or as if engaged in a process of persuasion?"

2. There is clearly an agent who can be construed as rhetor. If we find this rhetor analyzing audience and situation, arranging ideas for presentation to a client, addressing words specifically to the client (as opposed to addressing by formulae), and responding to audience response, we can call the therapist rhetorical.

[1]The writings of Richard Rabkin, Jurgen Ruesch, Jay Haley, William Glasser and others, provide interesting rhetorical parallels but first we must find out whether there is a set of questions we might apply to psychotherapeutic writing, in order to discover rhetorical propositions in the works.

We proceed with our inquiry and narrow the focus by examining the theory of a productive theorist of therapy, in this case, Harry Stack Sullivan.[2] Therefore, the original question, is stated "Is there a rhetoric in the writings of Harry Stack Sullivan?" The next task is to extract rhetorical aspects from Sullivan's work. This is accomplished by taking the canons of rhetoric, the sources of persuasion, some procedures of rhetorical behavior, and arranging them on the ordinate of a grid.[3] Then elements of rhetorical situations are placed across the abscissa.[4] This provides a number of cells, each containing a question. The questions designate the cells which then serve as containers to help gather ideas relevant to the rhetorical quality, if any, in Sullivan's work. These concepts are presented in Chart 1.

In other words, this chart contains components of rhetoric and, eventually, information from the works of Sullivan "stacked" in the appropriate cell. If there is no rhetorical information pertinent to a given cell, it remains empty. Partial filling indicates an incomplete rhetoric. Failure to fill any cell indicates no rhetoric at all. Thus the chart may be used to analyze the extent to which any set of writings, psychotherapeutic or otherwise, contains rhetorical information.

[2]Sullivan is chosen for good reasons. 1. He is renowned for his therapeutic procedure. 2. He provides a comprehensive and widely recognized theory of human beings as socially interacting organisms. 3. His focus on relationships connected by communicative interchanges provides interesting rhetorical parallels. See Patrick Mullahy, Psychoanalysis and Interpersonal Psychiatry, (New York, 1959), p. viii, and Silvano Arieti, ed. American Handbook of Psychiatry, Volume Two, (New York, 1959), p. 1417.

[3]See John F. Wilson and Carroll C. Arnold, Public Speaking as a Liberal Art, (3rd ed.), (Boston, 1974), p. 306, Aristotle, The Rhetoric, ed. Lane Cooper (New York, 1960), p. 7, and George Kennedy, The Art of Persuasion in Greece, (Princeton, 1963), p. 88.

[4]All forms of psychotherapy include elements of rhetorical situations: a goal to change behavior, an audience or sufferer who seeks relief from a healer, a message as strategy or healing influence conveyed by words, acts, and rituals to jointly participating persons, an assessment of effect to determine if the change has occurred. See Jerome Frank, Persuasion and Healing, (Baltimore, 1973), p. 2.

Chart I

Strategy for Rhetorical Analysis

of the Psychiatric Writings of Harry Stack Sullivan

		Goal A	Audience B	Message as Strategy C	Assessment of Effect D
Canons of Rhetoric / Sources of Persuasion	1. Invention	A1	B1	C1	D1
	2. Disposition	A2	B2	C2	D2
	3. Style	A3	B3	C3	D3
	4. Delivery	A4	B4	C4	D4
	5. Ethos	A5	B5	C5	D5
	6. Pathos	A6	B6	C6	D6
	7. Logos	A7	B7	C7	D7
	8. Cause	A8	B8	C8	D8
	9. Sign	A9	B9	C9	D9
Procedures of Rhetorical Behavior	10. generalization	A10	B10	C10	D10
	11. parallel case	A11	B11	C11	D11
	12. analogy	A12	B12	C12	D12
	13. classification	A13	B13	C13	D13

Because Sullivan is writing as a psychiatrist and not a rhetorician, it is important to specify rules for categorizing data into the four features common to rhetorical situations and all forms of psychotherapy (A-D). These components represent a prior analysis and the rhetorical concepts (1-13) a post analysis which the author is attempting to prove. In other words, rhetorical concepts (1-13) are tentative; a hypothetical guide to specify possible rhetorical dimensions falling from Sullivan's formulations. Therefore, aspects of (A-D) are now elaborated to strengthen the initial filing of information.

A. Goal in the analytical chart is a category to contain whatever Sullivan might say about human or therapeutic goals. Referring to a therapist's goal, for example, he states,

> "When a person comes to an interviewer with a problem, the assumption is that this person has been restrained from using the totality of his abilities. The problem of the psychiatrist in treatment is to discover what the handicaps to the use of his abilities are. . ."[5]

B. Audience includes references which explain how the therapist might analyze and adapt to the client. In Sullivan's view, for example,

> "The field of psychiatry is the field of interpersonal relations, under any and all circumstances in which these relations exist. . .a personality can never be isolated from the complex bundle of processes and their relations, organized from units of the physiochemical, the social, and the cultural worlds. . ."[6]

C. Message as strategy includes references to the therapist and client's use of artistic and inartistic strategies to modify the behavior of the other. Discussing how to summarize the psychotherapeutic interview Sullivan states, for example,

> "In a good many interviews there are things which are heard and inferred about the patient which are not included in the summary. For example, if the interviewer feels that the interviewee has an unfavorable prognosis, he almost never mentions it in a final summary. In other words, the interviewer attempts to avoid destroying what chance the person has."[7]

[5]Harry Stack Sullivan, Personal Psychopathology, (New York, 1972).

[6]Personal Psychopathology, p. 11.

[7]Harry Stack Sullivan, Psychiatric Interview, (New York, 1954), p. 210.

D. Assessment of effect includes whatever hints are offered on evaluating how the therapist assesses his effect on the client and how this knowledge alters clinical goals. Sullivan states, for example,

> "The interviewee's operations give clues to what he is experiencing, and in many cases these point toward the type of difficulty that he will have with anyone who impresses him as superior in capacity or in position. Thus it is quite important to realize that there are two groups of processes directed to the interviewer: one is the direct attitude of the interviewee toward him; and the other is that part of the interviewee's performances which are faithfully related to the supposed attitude of the interviewer."[8]

In short, this paper is attempting to answer these questions about Sullivan's work:

1. Does he advocate that the therapist examine goals to help audience adaptation?

2. Does he advise understanding the client in order to select techniques for achieving goals?

3. Does he suggest how to alter words and phrases to meet the needs of a particular client?

4. Does he include in his therapeutic system analysis of the effectiveness of the therapist's persuasive impact?

This study will seek to discover Sullivan's ideas about these matters by examining the bulk of his work.[9] The analysis is necessarily limited.

[8] Personal Psychopathology, p. 6.

[9] Harry Stack Sullivan, Personal Psychopathology (New York: W.W. Norton and Company, 1972). This source is important for two reasons: 1. It represents the most complete compilation of Sullivan's early thinking and 2. It is the only book Sullivan ever wrote and, is therefore essential to understanding the creation of his ideas in comparison to their interpretation by others. Most of Sullivan's work was developed from his lectures by his students. These lectures represent a main resource for this discussion and are compiled in the following books:

Harry Stack Sullivan, Psychiatric Interview, (New York: W.W. Norton and Company, 1954).

Harry Stack Sullivan, Conceptions of Modern Psychiatry, (New York: W.W. Norton and Company, 1953).

Harry Stack Sullivan, Interpersonal Theory of Psychiatry, (New York: W.W. Norton and Company, 1953).

It cannot draw any conclusions about psychotherapy in general. It can, however, find out if a given series of questions works in analyzing a body of writing about psychotherapy and make statements about Sullivan's positions on these matters. But even this is only a partial answer for then we must observe people who have been influenced by Sullivan to see if their practice fits what he advocated. That means the best we can give is an answer to the following question: "Do the writings of Harry Stack Sullivan give evidence of rhetorical content?" Thus, if we find the theorist, Sullivan, talking about the above ideas, we can take his comments as relevant to processes essentially rhetorical and call it his rhetorical theory. Now, how do we proceed?

Reiterating, we take the canons of rhetoric, the sources of persuasion, some common rhetorical acts. We arrange them on the ordinate of a grid. We put the elements of rhetorical situation across the abscissa, creating a number of cells, each of which contains a question to be asked about Sullivan's writings on psychotherapy. These are the questions:

Invention

A1. How does Sullivan advise thinking about goals in therapy?

B1. How does he advise thinking about the natural state behavior of the clien

C1. How does he advise thinking about what to say to the client?

D1. How does he advise thinking about analyzing the therapist's persuasive impact?

Disposition

A2. At what point are therapeutic goals revealed to the client?

9
cont.
Reference texts by other authors being used include:

Patrick Mullahy, Psychoanalysis and Interpersonal Psychiatry, (New York: Science House, 1970).

Lestor L. Havens, Approaches to the Mind, (Chicago: Little, Brown and Company, 1973).

Robert C. Carson, Interaction Concepts of Personality, (Chicago: Aldine Publishing Company, 1969).

Collectively, these works represent the bulk of Sullivan's published thought as well as the three major commentaries on that thought.

B2. What instruction does the therapist give the client about the process of therapy?

C2. How does the therapist order technique?

D2. When does the therapist communicate an evaluation to the client?

Style

A3. How is language used to achieve clinical goals?

B3. How is the client influenced by the therapist's style of speaking: the choice of language?

C3. How does language function as therapeutic strategy?

D3. How is language used to convey clinical evaluations to the client?

Delivery

A4. How is the content of what is said adapted to the client to accomplish goals?

B4. How does the therapist order technique?

C4. What special devices are recommended?

D4. What are the guidelines for dispensing evaluations to the client?

Ethos

A5. How important is a therapist's credibility to a client's acceptance of therapeutic goals?

B5. How does the superordinate role of the therapist influence the client's subordinate behavior?

C5. How does the psychotherapist assess the client's credibility?

D5. How does the therapist determine his or her own personal impact on the client?

Pathos

A6. How do emotions thwart clinical goals?

B6. What effects emotional attitudes in the client?

C6. What are observable cues which indicate emotional discomfort?

D6. How does the therapist determine emotional changes in both the client

and therapist during the therapeutic transaction?

Logos

A7. How do clinical goals suggest a reasonable alternative to the client?

B7. What role does the client play in establishing reasonable alternatives?

C7. How does the therapist employ reasoned arguments to communicate with clients?

D7. How does the therapist determine if the client's communication is reasonable?

Procedures for Analyzing Statements About Rhetorical Behavior (NOTE! Each of the substantive kinds of argument is given its own cell as it is appropriate to the following set of questions:)

A8-13. How does the therapist seek to achieve clinical goals through the substantive kinds of argument?

B8-13. How is the client affected by substantive types of reasoning?

C8-13. How does the therapist apply substantive forms of argument to alter the client's behavior?

D8-13. How is substantive argument used to convey the therapist's evaluation to the client?

A preliminary analysis of Sullivan's work reveals that the analytical grid provides three categories of questions. These categories are presented in Chart 2. Questions which proved most pertinent and productive to the investigation are listed in the first column "Pertinent cells." Questions which were redundant in that their answers were explained more clearly in other cells are listed in the second column "Explained in adjacent cell." These questions were answered in the content of answers to questions in the "Pertinent" column. Questions eliminated because they did not evoke information when applied to the text of Sullivan's work are listed in the third "Not applicable" column. That is, Sullivan had nothing to say about these categories and, therefore, his rhetoric is incomplete.

Chart 2

Preliminary Analysis of Findings

Pertinent cells	Explained in adjacent cell	Non-applicable to text
A1	D2	A2
B1	A3	B2
C1	B3	A5
D1	D3	B5
C2	B4	D5
C3	A4	A6
C4	D4	D6
C5	B6	A7
C6	B7	A8-13
C7		B8-13
C8		C8-13
		D8-13

Analysis of responses to questions in Row 1 reveal a partial rhetorical theory in Sullivan's work. The preponderance of productive cells yields information concerning "Invention," the preeminent rhetorical canon. Strategic offerings tended to produce general advisories as in C1-8. There was little information about more explicit strategies (C9-13 or about "goal," "audience," "assessment of effect" 2-13).

Space limitations inhibit a detailed discussion of each cell but let us consider the four canons: invention, disposition, style and delivery with reference to heading C. Message as Strategy.

C1. Invention: How is the content of what is said adapted to the client to accomplish goals?

Sullivan suggests interesting ways for the therapist to think about dysfunctional messages communicated by a client. His position is that all pathology is accompanied by a rational, though inartistic non-consensual message exchange.

> "The most extraordinary phenomenology that I have observed...seems to include nothing beyond explanation on the basis of empathic exchange, coupled with relaxation of the self-conscious pursuit of consensually valid information...?"[10]

By "consensually valid information" Sullivan means "...the ability to move words around to the point that they convey what you mean to the person to whom you are going to speak."[11] Here is an assertion of the need for a rhetoric with the details spelled out. In regression, for example,

> ...The whole interest system has shriveled to a historically earlier stage in his growth and there are no evidences that factors formerly interesting to him as a more adult personality retain any validity. They are simply unnoted or treated as nuisances.[12]

And what we might call the "final inartistic proof," suicide, is a message

[10] Personal Psychopathology, p. 75.

[11] Psychiatric Interview, p. 152.

[12] Personal Psychopathology, p. 78.

communicated to leave a permanent scar on the object personality.[13]

The point is, before the therapist can adapt the content of the therapeutic message there needs to be an understanding of the strategic nature of the client's inartistic proof so that the therapist may circumvent or take control of, rather than be controlled by, their destructive force. This circumvention allows the therapist to fulfill a primary goal: to get the client to engage in more adaptive (artistic) kinds of behavior. Such change as we shall see is adapted to the idiosyncratic needs of the client and stimulated with artistic devices employed by the therapist.

C2. Disposition: How does the therapist order technique?

Disposition is an important consideration in Sullivanian thought both in reference to the entire therapeutic interview and with reference to delivering specific pieces of information. With reference to the entire interview Sullivan suggests four phases: inception, reconnaisance, detailed inquiry, and termination. The inception phase is used

> "...not only to promote a feeling of confidence on the part of the patient, in the interviewer's straight forwardness, but also to provide an opportunity for the client to amend the presumptive data which the psychiatrist may have acquired from another source...Finally an adequate reason for the conference must be established; that is, the psychiatrist should obtain adequate justification for the use of his skill."[14]

The reconnaisance

> ...consists in obtaining a rough outline of the social or personal history of the patient. In this stage, the interviewer is concerned with trying to get some notion of the person's identity--who he is and how he happened to get to be the person who has come to the office...[15]

The third step is the "detailed inquiry." Here Sullivan provides a set of heuristics based on his developmental epochs.[16] But, he warns,

[13] Ibid. p. 84.

[14] Psychiatric Interview, p. 40.

[15] Ibid.

[16] Ibid. p. 157. The epoch stages of personality provide the psychotherapist with a way to characterize and thereby to help disturbed patients by learning the

> If the interviewer's development of the inquiry too clearly follows the developmental eras as I have set them up, he will, as it were, be warning the interviewee of what should be produced. In other words, he will be telling the interviewee what security operations to use to defeat the purpose of the interview.[17]

The fourth step involves terminating the interview. Sullivan offers four suggestions for facilitating this smoothly:

> ...(1) the interviewer makes a final statement to the interviewee summarizing what he has learned during the course of the interview; (2) the interviewer gives the interviewee a prescription of action in which the interviewee is now to engage; (3) the interviewer makes a final assessment of the probable effects on the life-course of the interviewee which may reasonably be expected from the statement and prescription; and (4) there is the formal leave-taking between the interviewer and the interviewee.[18]

Sullivan also suggests that the strategic persuasiveness of ordering is also a factor in extracting isolated fragments of information within one session--particularly information perceived sensitive by the client. Says Sullivan:

> Thus when a certain question is going to touch on a topic or field regarding which the patient feels insecure or anxious, the psychiatrist makes a little preliminary movement which indicates that he is quite aware of the unpleasantness that will attend this question, but also that it is obviously necessary that he should know the information; in other words, he gives the patient a little warning to brace himself...[19]

In a more general vein he cautions, "You can't be too precise in questions without getting the patient somewhat startled. In other words, you ask general questions fairly often merely as a method of transition, to get a topic onto the open. Having accomplished this, you become specific."[20]

Sullivan illustrates how he might pose a question so the client provides a reliable response.

> First I verify the fact that the interviewee does or does not know

16 cont.
limits of relevance in their behavior from studying factors of growth from birth onward. The most complete explication of Sullivan's epoch stages is found in Conceptions of Modern Psychiatry.

17 Ibid. p. 157.

18 Ibid. p. 210.

19 Ibid. p. 31.

20 Ibid. p. 163.

> when puberty happened, but at least knows what I am talking about, and then I learn if there were any unfortunate ideas connected with the event. With this indirect approach I may come to know something which is reasonably trustworthy.[21]

At the end of each session, the psychiatrist attempts to lower anxiety. Like any rhetor, he must satisfy the exigences he arouses. "One of the heaviest responsibilities of the psychotherapist is to try to get the patient on the downgrade of anxiety before the end of a session, instead of in a state where he is becoming increasingly anxious..."[22]

In short Sullivan sees the way in which a session unfolds as very important to the success of therapy. He suggests that therapeutic interviews go through a series of phases whose sequence represents an orderly process which tells the therapist what he or she needs to do, and the order in which it can be done. With regard to a single, therapeutic instance, Sullivan suggests that acquiring sensitive material is facilitated by strategic ordering.

C3. Style: What specific devices are recommended?

Sullivan was aware of the impact style has in the psychiatric interview. The stylistic devices he mentions include references to how the therapist gets the client to: supply reluctant information, clarify fuzzy responses, keep talk relevant, give up control of parataxic distortion. Consider how Sullivan uses hyperbole as a device to extract information from a reluctant client-audience:

> Was it your first love? The answer may be "yes," at which one may say, "Is that so? That's most unusual." Now, nobody cares whether it's most unusual or not. In fact, it is fairly unusual, but it isn't most unusual. The "most unusual" makes it an issue, with the result that the informant feels that it requires a little explanation...[23]

Another illustration makes this point clearer.

> Now when I say a thing sounds amazing, the patient feels very much on the spot; he feels that he must prove something, and he tells me

[21] Ibid. p. 16.

[22] Ibid. p. 223.

[23] Ibid. pp. 8-9.

> more about how wonderful his friend's motivation is. Having heard still more, I am able to say: "Well is it possible that you can think of nothing he ever did that was at least unfortunate in its effect?" At this the poor fellow will no doubt remember the elopement of his wife...[24]

In other words, therapists can intentionally overstate their case and employ misdirection to stimulate clients into refining their position.

Sullivan also finds utility in stating the obvious and then acting surprised at the strong response which this ploy elicits in the client:

> ...putting the obvious into words often markedly improves things. Then the patient can say with considerable force, 'Yes...I don't like to talk about that.' Then I can be amazed, and my amazement means, 'Well. I don't see that that follows at all. What's so difficult about it? How come you dislike it? Is it supposed not to be respectable or something?'[25]

This technique is especially useful when the client is unduly upset and the therapist can ask:

> Do you feel I'm questioning you? At that, any completely sane person would say quite angrily, 'I know you are questioning me.' But people who are upset are so glad to have anything that looks like a straw thrown to them that they don't notice the preposterous character of such an inquiry, and actually feel better about what the interviewer is doing, having somehow slipped away from the anxiety connected with being questioned.[26]

That is, stating the obvious can lighten intense anxiety by suspending the painful probing and providing a measure of cognitive distance in which the client can gain some breathing room.

Repetition, too, can lighten emotionally upsetting material. Sullivan explains:

> Having thus created the impression that this was by no means the first time that I had heard this sad and somewhat erroneous story, I would say, 'Now tell me, how much did you masturbate to accomplish this ruin?'--I would endeavor to get across some faint satire by this repetition of ruin.[27]

[24] Ibid. p. 21.

[25] Ibid. p. 230.

[26] Ibid. p. 118.

[27] Ibid. p. 227.

Sullivan also suggests stylistic ways for the therapist to connect the flow of ideas in the therapeutic transaction. Transitions in therapy enable the therapist to move around in the interview in such a way that the client always has some idea of what he is driving at.[28] Following are three kinds of recommended transitions with examples for each:

1. The "smooth" transition "...moves from one thing to another quite smoothly, so that the other person feels that this is really a very clear, collaborative inquiry..."[29] For example, "Well, now, that brings up the topic of so and so. I wonder if by any chance you've had experience of that kind?"[30]

2. With the "accented" transition "...you rustle your feathers, as it were, and somehow indicate that, 'Well, the world is about to undergo some mild change.' ...In this way the later data is not poisoned by the exploration that was in progress before, as it might be with a smooth transition."[31] If, for example, someone has been showing Sullivan what a lovely soul he has, "...I will then sort of growl a bit as a preliminary to saying something like, 'With what sort of person do you find yourself hateful?'"[32]

3. With "abrupt" transition "...a new topic is introduced which has relevance, but which is introduced at what would be described as a socially awkward point, and without warning. This sort of thing may be done to avoid, or to provoke anxiety..."[33] For example, "you're getting quite anxious, aren't you? Well, what's the hurry about this? We can drop it and go on about so and so, can't we?" The abrupt transition is properly done "When the patient

[28] Ibid. p. 46.

[29] Ibid. pp. 47-48.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Ibid.

is taken through an upsetting period to definitely reassuring material, or from something that was going on with greatly increasing risk to the situation to something which is remarkably reassuring."[34]

C4. Delivery: What special devices are recommended?

Sullivan was somewhat unique in emphasizing that "...the processes in interview situations follow this general pattern of all interpersonal processes."[35] What this means is that any relationship follows a familiar pattern: "...first, one attempts to avoid arousing anxiety, and second, one acts to restrain its development. Reassurance might be termed a third technique..."[36]

This is an important notion because clients are often highly skeptical, and the therapist must dispose messages in a way which circumvents their defensive operations:

> ...then the reciprocal pattern of activity which would appear in a simple interpersonal situation would be reassurance by implication--by saying something which would have very little to do directly with the other person's self esteem, but would, on further elaboration, be seen to imply a favorable view or hopeful outlook...[37]

Reassurance is also facilitated by a professional demeanor which excludes real surprise from one's repertoire of therapeutic responses. Sullivan states, "...I receive all this information without surprise, for an expert is not surprised at getting what he wants."[38] Similarly unwise is spontaneity.

> While the appearance of spontaneity is desirable in the interviewer's responses to affective movements and changes in the patient, these responses should never be automatic in the way they might be with his wife, or his child, or the bus driver, for in the very act of the automatic response, selective inattention probably eliminates about half of the useful data. No interviewer can afford this.[39]

[34] Ibid. pp. 48-49.

[35] Ibid. p. 17.

[36] Ibid.

[37] Ibid. p. 129.

[38] Ibid. p. 77.

[39] Ibid. p. 128.

But thoughtful responses elude everyone at some time, and Sullivan suggests that during these moments "...the interviewer's inquiry progresses from expressed puzzlement to direct questions and, if necessary, finally to the use of 'as if'"[40]

Tonal and facial cues are also considered important facets of message delivery in the interview.[41] The face becomes increasingly important in conveying consensual validity of sentience.

> The importance of the face thus grows rapidly, the more in that sentience arising from other faces is chiefly visual, of the type peculiarly easy to elaborate in the direction of consensual validation. This is not so much the case with the voice...[42]

The foregoing is a discussion of Sullivan's view on most therapeutic interaction but he recognizes there are several manifestations exhibited by severely troubled clients which necessitate special modes of therapeutic delivery. For example, while direct eye contact is important with many clients, it can be counterproductive with schizophrenics. Sullivan explains:

> Schizophrenics are very shy people, low in self-esteem and subject to the suspicion that they are not particularly appreciated or respected by strangers. Like many other people, they are rather sensitive to scrutiny, to inspection, and to being 'looked in the eye'...[43]

And the catatonic schizophrenic, must be dealt with even though the therapist receives no responses.

> The catatonic schizophrenic, who is often mute and engages in practically none of the communication by gesture on which we ordinarily depend seems to many of us very strange and very inaccessible...I must proceed with only the knowledge that he is a person who has a profound disturbance of interpersonal relations which manifests itself in a way that I am by now somewhat familiar with...Therefore, I reduce my attempted communication to certain things which seem to me so very highly probable that the chances of their being irrelevant are small... The objective is not primarily my obtaining information, but the patient's

[40] Ibid. p. 134.

[41] Ibid. p. 6.

[42] Personal Psychopathology, p. 6.

[43] Psychiatric Interview, pp. 5-6.

receiving some durable benefit...[44]

Dealing with the paranoid personality is a special case again. Warm reassurance in this instance can be counterproductive.[45]

> Thus it becomes almost a first principle for the therapist to be distant in dealing with paranoid people. He may, in fact, often be rather forbidding. I am sure that I have received a great deal of information from some paranoid people because they felt I was a thoroughly disagreeable person. I asked unpleasant questions unpleasantly--and got some answers. If I had asked unpleasant questions in a friendly way, these people would probably have gotten all tied up in knots about what I was trying to convict them of...[46]

In short, Sullivan deals with message as strategy within the psychiatric interview in reference to what will support processes common to any pattern of interpersonal relationships and also in reference to some symptomatic manifestations which require delivery systems uniquely their own.

Analysis of responses to the questions posed earlier in this inquiry indicate a partial rhetoric in Sullivan's work. We find:

1. Goals are sought in a particular situation with a specific client-audience.

2. The therapist seeks to particularize the situation with a client to discover information and overcome resistance in the given case.

3. The objective of therapists' persuasion is defined as refutation of non-consensual messages by the client and replacement with consensus.

4. To facilitate the incorporation of strategies, particular stages of the therapeutic process are defined.

5. Sullivan gives advisories on delivery relative to voice, face, and eye contact.

The rhetoric is incomplete because Sullivan offers no concept of exigence,[47]

[44] Ibid. pp. 206-207.

[45] Ibid. p. 232.

[46] Ibid.

[47] Bitzer created his concept of rhetorical situation specifically for public

and his implied rhetorical theory is only fragmentarily formed.[48] But the methodology provided in this study gives us a coherent and consistent way to begin remedying this incompleteness by examining other theorists of psychotherapy. Jurgen Ruesch, William Glasser, even Carl Rogers, for example, might provide us with abundant information to fill the cells left empty in the present investigation. But even this is only part of an answer for then we need to analyze therapy in process of therapists who purport to follow the particular psychotherapeutic theory in question. With studies of this kind we may begin to: 1. Devise and refine strategies for use in predictable, therapeutic situations and 2. Adapt familiar rhetorical criteria of probable effectiveness for application in therapeutic situations.

[47] cont.
situations, but exigences also occur in therapeutic and other interpersonal situations. If therapists were attuned to this concept, they would be in a better position to discover what is possible, allowable, and invited in any given circumstance. See Lloyd Bitzer, "The Rhetorical Situation," Philosophy and Rhetoric, Vol. 1, 1968, pp. 6-7, and Carroll C. Arnold, Criticism of Oral Rhetoric, (Columbus, 1974), p. 30.

[48] Message is the only dimension of rhetorical experience reasonably well treated in Sullivanian ideas. But we could extend counsels to therapists to cover more fully goals, audiences, assessments of effect.